STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106
In CT 1-800-504-1102 ext 8413 (860) 241-8413 Fax (860) 525-6018
www.ct.gov/trb
October 2006

MEDICARE SUPPLEMENTAL HEALTH INSURANCE CHANGE FORM FOR JANUARY 1, 2007

Health Coverage Change Requirements

This is your annual opportunity to add or cancel coverage to your health insurance options through CTRB.

If you are:

Adding coverage:	submit a form no later than November 15, 2006
Dropping coverage:	submit a form no later than November 15, 2006
Canceling all coverage:	submit a form no later than November 15, 2006
No changes:	DO NOT SUBMIT A FORM

Each insured person covered under the TRB health plan who wants to change their coverage must submit one change form. Two change forms are enclosed. One for the member and one for the spouse; if applicable. Once you enroll in a specific plan, no changes are allowed until January 2008.

New Rates Effective January 1, 2007

Coverage Type	Monthly, Per Person
Medicare Supplement with Prescriptions	$ 87.00
Medicare Supplement with Prescriptions & Dental	$127.00
Medicare Supplement with Prescriptions, Dental, Vision & Hearing	$131.00

Coverage Changes Effective for January 1, 2007

The members cost for generic drugs has been reduced to 5%, for both retail and mail order. After the first 2 refills, retail generics will increase to 10%.

The Major Medical deductible has been eliminated.

TRB will provide an additional 60 days of hospitalization for each Medicare approved extended hospital stay at 100%.

PLEASE NOTE:

Walgreens Drug Stores do not participate with Merck Medco and TRB.

Contact Merck Medco (1 800-711-0917) for prescription questions.
Contact Delta Dental of New Jersey (1 800-452-9310) for dental questions.
Contact Stirling & Stirling (1-800-447-6689) for medical, vision and hearing questions.

Please inform TRB of any address changes in writing at the above address.

PLEASE RETAIN THIS DOCUMENT

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21 GRAND STREET HARTFORD, CT 06106
phone 860-241-8400 fax 860-525-6018
Toll Free 1 800 504-1102
Website www.ct.gov/trb

HEALTH INSURANCE CHANGE FORM

This form is to be completed by members and spouses who are currently enrolled in a TRB Health Plan and are adding, dropping or terminating coverage.

- SUBMIT A COPY OF YOUR MEDICARE CARD EVEN IF YOU ARE CURRENTLY ENROLLED IN A STIRLING & STIRLING PLAN AND WISH ONLY TO CHANGE YOUR COVERAGE.
- ONE FORM FOR EACH PERSON CHANGING COVERAGE MUST BE RECEIVED BY NOVEMBER 15, 2006.
- All changes will be effective JANUARY 1, 2007.
- **DO NOT SUBMIT THIS FORM IF YOU ARE STAYING IN YOUR CURRENT PLAN**.

	Cost per person per month	**Check one(x)**
Medicare Supplement with Prescriptions	$ 87.00	☐
Medicare Supplement with Prescriptions and Dental	$ 127.00	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$ 131.00	☐
Cancel all TRB coverage effective January 1, 2007		☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT.

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number

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HEALTH INSURANCE CHANGE FORM

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	Cost per person per month	Check one(x)
Medicare Supplement with Prescriptions	$ 87.00	☐
Medicare Supplement with Prescriptions and Dental	$ 127.50	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$ 131.50	☐
Cancel all TRB coverage effective January 1, 2007		☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Social Security Number	Medicare Number	Date of Birth

PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT.

Enrollee's Signature	Date

If you are enrolling as the spouse of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number